STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155245	A. BUILDING	00	02/01/2012
		100240	B. WING	ADDRESS, CITY, STATE, ZIP CODE	02/01/2012
NAME OF I	PROVIDER OR SUPPLIE	₹		86TH ST	
CASTLE	TON HEALTH CAR	RE CENTER		IAPOLIS, IN 46256	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F0000	REGULATORY OR	LISC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
1 - 0000					
	This visit was for a Recertification		F0000		ì
	and State Lice	nsure Survey.			
	•	January 23, 24, 25, 26,			
	27, 30,31, and	February 1, 2012			
	Facility numbe	r: 000140			
	Provider numb				
	AlM number:	100266840			
	Survey team:				
	Connie Landm	an, RN-TC			
	Diana Zgonc, F	RN			
	Census bed ty	•			
		34			
	Total: 6	64			
	Census payor	tvpe:			
		6			
		2			
	Other:	6			
	Total: 6	64			
	Stage 2 Sampl	e: 37			
	These deficien	cies also reflect State			
		n accordance with 410			
	IAC				
	16.2.				
	O and life				
	1	completed on February			
	3, 2012 by Bev	raulkner, KIN			
	<u> </u>			<u> </u>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000149

PRINTED: 02/22/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155245	A. BUILDING B. WING		02/01/2012
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	l
				86TH ST	
	TON HEALTH CAR			IAPOLIS, IN 46256	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8KO411

Facility ID: 000149

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 00 COMPLET			
		155245	B. WIN	G		02/01/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CASTLE	TON HEALTH CAR	E CENTER			86TH ST IAPOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	\TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
F0155 SS=D	The resident has t treatment, to refus	•					
		arch, and to formulate an					
	advance directive as specified in paragraph (8) of this section.						
	Based on recor	rd review and	F01	55	Element #1 What corrective		02/21/2012
	interview, the fa	acility failed to ensure			action(s) will be accomplished for		
	resident's rights	s to refuse the			those resident(s) found to have been affected by the deficient		
	influenza vacci	ne was honored for 1					
	of 5 residents r	eviewed for influenza			facility to see that all resident(
	vaccine in the	Stage 2 sample of 37			consents (to administer or not		
	(Resident # 74).			1		
		•					
	Findings includ	e:					
	J						
	The record for	Resident #74 was			Resident's #74 (Legal		
	reviewed on 1/3	30/12 at 2:00 P.M.			_ · ·)	
	Diagnoses for I	Resident #74 included			receiving the influenza vaccine		
	_				_		
					How will you identify other		
	••	-			residents having the potential		
	, ,					ient	
		•			1 -		
	The resident's	Power of Attorney				,	
					be affected by this practice. T		
					signed consent stating to		
						r	
		_				_{t Δ}	
		•			medication sheet will be creat		
	Taconic was no	A mantod at tillo tillo.			for the nurse administering the		
	 The Influenza/F	Pneumonia vaccine log			vaccine to sign that she did		
		•					
	'	:20 A.M., indicated			• •	_{ie}	
		should not be given the				-	
	vaccine.	onosia not bo given the			resident and/or legal		
	(8) of this section. Based on record review and interview, the facility failed to ensure resident's rights to refuse the influenza vaccine was honored for 1 of 5 residents reviewed for influenza vaccine in the Stage 2 sample of 37 (Resident # 74). Findings include: The record for Resident #74 was reviewed on 1/30/12 at 2:00 P.M. Diagnoses for Resident #74 included but were not limited to, Dementia, Hypertension, Insomnia, Depression, anxiety, Hyperlipidemia, Dysphagia and Glaucoma. The resident's Power of Attorney (POA) signed the "Influenza Vaccine Administration Consent Form" on admission to the facility on 8/26/11. The POA checked "No"; the influenza vaccine was not wanted at this time. The Influenza/Pneumonia vaccine log provided by Medical Records Director				practice; It is the policy of this facility to see that all resident(consents (to administer or not to administer) the Influenza Pneumoionia Vaccine are followed with accordance to (Residents; or Legal Representative) wishes. Resident's #74 (Legal Representative and Physician was notified about resident receiving the influenza vaccine against her instructions not to give the influenza. Element #2 How will you identify other residents having the potential be affected by the same defici practice and what corrective actions will be taken; All residents have the potential to be affected by this practice. T signed consent stating to administer or not to administe the influenza vaccine will be placed into the residents charmedication sheet will be creat for the nurse administering the vaccine to sign that she did review consent sheet prior to giving the vaccine. The medication sheet will also stat as to the education given to	to ient r t. A ed	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155245	B. WING		02/01/2012	
CASTLE	PROVIDER OR SUPPLIEI	E CENTER	7630 E INDIAI	ADDRESS, CITY, STATE, ZIP CODE E 86TH ST NAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	Screening/Risk provided by Me on 1/27/12 at 1 the resident revaccine on 10/ The "Medication Record" (MAR received the value of 1/3 indicated the fall fall fall fall fall fall fall fal	edical Records Director 0:45 A.M., indicated ceived the Influenza 1/11. on Administration indicated the resident accine on 10/1/11. the Medical Records 0/12 at 10:30 A.M., accility made a mistake e should not have been		representative prior to administering the vaccine. The D.O.N. or designee will monitor all new admissions to ensure policy is followed. The D.O.N designee will also monitor at immunization time October 1s thru March 31st that all consequence resident's, legal representative wishes along with noting education was given. Element What measures will be put into place or what systemic change you will make to ensure that the deficient practice does not recommend that the deficient practice does not recommend to a laspects of reviewing the signed consent prior to giving the linfluenza/Pneumonia Vaccine. Any nurse who fails to comply with said safety guidelines in reviewing consents prior to administering will be progressively disciplined up to and including termination. Element #4How the corrective actions will be monitored toensure deficient practice will not recur; ie,. what quality assurance program will be put into place; and completion date. At the monthly Quality Assurance Meeting tracking o consents and administration of the Influenza/Pneumonia Vaccine addressed. If necessary and action plan will be written by the Administrator and monitored	or or or t ents to e t #3 ces ne eur; on and l ed . f f f cine s will n	

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Event ID: 8KO411

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	00	(X3) DATE COMPI		
		155245	A. BUILDING B. WING		02/01	/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	-	
CASTLE ⁻	TON HEALTH CAR	E CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)) BE PRIATE	COMPLETION DATE
TAG	REGULATORT OR	LSC IDENTIFT ING INFORMATION)	TAG	weekly until resolution.		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8KO411

Facility ID: 000149

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155245	B. WING		02/01/2012	
			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEI	R		86TH ST		
CASTLE ⁻	TON HEALTH CAR	RE CENTER		IAPOLIS, IN 46256		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0223	The resident has	the right to be free from				
SS=B	verbal, sexual, ph	ysical, and mental abuse,				
		ent, and involuntary				
	seclusion.					
	The facility must r	not use verbal, mental,				
	sexual, or physica					
		voluntary seclusion.				
<u>'</u>	Based on reco	•	F0223	Element #1 What corrective	02/21/2012	
		acility failed to ensure		action will be accomplished for		
		treated with dignity,		those residents found to have		
		erbal abuse, and failed		been affected by the deficient		
		,		practice; It is the policy of this		
		lent's personal property		facility that every resident is from		
	was safe from			from verbal, sexual, physicial, mental abuse including corpor		
	_	reviewed in the Stage 2		punishment and involuntary	aı	
	Sample of 37 (Residents #77, #93,		seculusion. This facility contin	ues	
	and #83).			to observe, teach and monitor		
				abuse prevention. All new		
	Findings includ	de:		employees upon hire are chec		
	Ŭ			with (3) references, a backgro		
	Three abuse Ir	nvestigations were		check and license review (whe	en	
		view on 1/31/12 at 2:00		applicate). The facility has an		
	· .	dministrator and the		ongoing abuse training, in-servicing, which is held a		
				minimum of (4) times annually		
	following was r	ioled.		Department heads, charge	-	
		. D : 1		nurses and all staff are		
		for Resident #77 was		in-serviced on recognizing state		
	reviewed on 2/	/1/12 at 9:30 A.M.		burnout. Residents are taught	(2)	
				times annualy during monthly	.	
	Diagnoses incl	luded, but were not		Resident Council on how to re		
	limited to, mus	cle weakness, difficulty		mistreatment, theft, and all asp of abuse. Who and how to rep		
	walking, chron	ic airway obstruction,		with free from reprisal. Posting		
	_	tension, chronic		of contact numbers on reportir		
		disease, and atrial		concerns and abuse are poste	~	
	fibrillation.			through-out the facility for		
	mormation.			residents, families and visitors		
	An incident res	ported to the DON		use. Element #2 How will you		
		ported to the DON		identify all residents having the		

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Event ID: 8KO411

Facility ID: 000149

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	A. BUILDING 00		COMPLETED	
		155245				02/01/	2012
			B. WING		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP CODE		
					86TH ST		
CASILE	TON HEALTH CAR	E CENTER		INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF COR			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(Director of Nu	rsing) and			potential to be affected by the		
Administrator on 12/15/11, indicated				same deficient practice and w			
		vas currently at the			corrective action will be taken;		
		•			resdients have the potential to		
		a fall, but she had			affected by possible abuse. The		
		laughter she did not			facility will continue to teach a	nd	
		pack to the facility			monitor and encourage all to		
	because the C	NA caring for her (CNA			report any and all alleged or actual abuse. The facility will		
	#3) and the nu	rse (LPN #2) were			continue to follow its Abuse Po	olicy	
	mean to her ar	nd yelled at her			and Procedures. The Social	Jiioy	
	because she h	•			Service Direcor or designee w	ill	
	investigation was immediately started,				continue to monitor and intervi		
	_	nd LPN #2 were			residents on concerns and		
		id LPN #2 were			treatment by staff, visitors or		
	terminated.				other residents, (2) times weel	kly,	
					any concerns during these		
	2. The record	for Resident #93 was			monitoring or interviews with b	e	
	reviewed on 2/	1/12 at 9:35 A.M.			immediately reported to the		
					Administrator for investigation		
	Diagnoses incl	uded, but were not			and follow up. Element #3 Wh		
	_	oarthrosis, difficulty			measures will be put into place what systemic changes you w		
		•			make to ensure that the deficie		
		oint replacement,			practice does not recur; At an		
	muscie weakne	ess, and anemia.			staff in-service held February		
					2012, the Adminisitrator review		
	An incident rep	orted to the			all Policies and Procedures or		
	Administrator a	and DON on 8/13/11,			resident abuse and prevention	١.	
	indicated the re	esident reported the			Residents rights and staff burr	nout	
		N #5) embarrassed her,			were also reviewed. All staff		
	,	put her knee dressing			were instructed that the		
		n investigation ensued			Administrator must be notified		
	_	<u> </u>			immediately on all allegations		
	and RN #5 was	s terminated.			reports of abuse. Element #4		
					How the corrective actions will monitored to ensure the defici-		
	3. The record	for Resident #83 was			practice will not recur; ie what		
	reviewed on 2/	1/12 at 9:20 A.M.			quality assurance program wil		
					put inot place; and completion		
	Current diagno	ses included, but were			date. While the facility		
	_	Alzheimer's Disease,			recognizes that it cannot contr	ol	
	,	NATIONAL S DISCOST,	1		_		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155245	B. WIN	G		02/01/2	2012
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
040715	TON HEALTH OAD	E OENTED			86TH ST		
CASTLE	TON HEALTH CAR	E CENTER		INDIAN	APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	E COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)		TAG	the actions of others, it can ke	en en	DATE
	gastroesophageal reflux disease, depression, anxiety, fibromyalgia,				in place all measures to assist		
	•	, ,			the prevention of resident abus	se.	
	hypertension, a deficiency.	and vitamin D			At the monthly Quality Assurar		
	deliciency.				Meetings tracking of all previous reported or reports of alleged	usly	
	An incident on	3/26/11, witnessed by			abuse will be discussed. Any		
	the weekend s	-			patterns or concerns will be		
	immediately re	•			addressed. If necessary an		
	•	and Director of Nursing			action plan will be written by the administrator and monitored	ie	
		sident was noted to be			weekly until resolution.		
		vas being propelled to			,		
		n by CNA #4. CNA #4					
	_	another area that day,					
	and told the su	pervisor she was just					
	helping out. Th	ne supervisor asked					
	Resident #83 v	vhat was wrong, and					
	the resident rep	olied her wedding ring					
	and engageme	ent rings were missing					
	off her finger.	The supervisor noted					
	her ring fingers	were red and had the					
	indentations of	the rings present. The					
	•	instructed to call the					
	· ·	he did. The supervisor					
		CNA to remain so she					
		iewed by the police,					
		facility without notice					
	· ·	or. CNA #5 was					
	terminated.						
	-	view with the DON on					
		A.M., she indicated if					
		ny doubt as the result					
		tion, the employee is					
	terminated.						

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Event ID: 8KO411

Facility ID: 000149

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PRINTED: 02/22/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155245			A. BUILDING B. WING	COMPLETED 02/01/2012		
	PROVIDER OR SUPPLIER	ENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	(EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PERCEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	The residents wer care plans update The CNAs and nu removed from the immediately pend results. The prop	erviews were done. e assessed and d as appropriate. rses had been building ing the investigation				

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Event ID: 8KO411

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	_G 00	COMPLETED
		155245	B. WING		02/01/2012
			_	REET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			330 E 86TH ST	
CASTLET	ΓΟΝ HEALTH CAR	E CENTED		DIANAPOLIS, IN 46256	
CASTLE	IONTIEALITICAN	E CENTER	IIN	DIANAFOLIS, IN 40250	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREI	CROSS-REFERENCED TO THE APPRO	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA		DATE
F0279	A facility must use				
SS=D		velop, review and revise			
	the resident's com	prehensive plan of care.			
	-	evelop a comprehensive			
	•	resident that includes			
		tives and timetables to			
		medical, nursing, and osocial needs that are			
		mprehensive assessment.			
	identified in the co	impremensive assessment.			
	The care plan mus	st describe the services			
	that are to be furnished to attain or maintain				
		est practicable physical,			
		osocial well-being as			
		83.25; and any services			
	that would otherwi	se be required under			
	•	ot provided due to the			
		e of rights under §483.10,			
		to refuse treatment under			
Į	§483.10(b)(4).				
	Based on recor	d review and	F0279	Element #1 What corrective	02/21/2012
	interview, the fa	acility failed to ensure		action(s) wil be accomplish	
	health care pla	ns were individualized		those residents found to hat been affectd by the deficien	
	•	dents reviewed for		practice; It is the policy of	
		care plans, and failed		facility that comprehensive	
		plans were developed		plans are developed which	
				measures objective and	
		ure areas for 1 of 22		timetables to maintian the I	nighest
		were reviewed for		practicable physical, ment	al,
	•	f care plans in a Stage		psychosocial wellbeing, ald	ong
	2 Sample of 37	(Residents #78 and		with medical, nursing need	
	#91).			identified in the comprehen	
				plan of care. Resident #78	-
	Findings includ	e:		Assessment was re-written	
				reflect his "individual intere	
	1 The record to	for Resident #78 was		Resident #91 redness to he has resolved. Resident #48	
		30/12 at 8:45 A.M.		(Legal Representative) and	
	TOVIEWEU UIT 1/	50/ 12 at 0.75 A.IVI.		(Physician) were notified al	
				resident #48 receiving the	
	Current diagno	ses included, but were		Toolson in to receiving the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		I DDIG	00	COMPLETED	
		155245		LDING	<u> </u>	02/01/2012)
		<u>l</u>	B. WIN		ADDRESS CITY STATE ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
04071	TON HEATTH CAS	DE OENTED			86TH ST		
CASTLE	TON HEALTH CAR	KE CENTEK		INDIAN	IAPOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		IPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
		delirium, history of MS			influenza vaccine even though		
	(multiple sclerosis), HTN				(Legal Representative) reques		
	(hypertension)	, hypercalcemia, DM			not to give the influenza vacci Element #2 How will you iden		
		tus), trigeminal			other residents having the	ury	
	neuralgia, and				potential to be affected by the		
	l lie a. a. g.a., a.i.a				same deficient practice and w		
	The Activity As	ssessment, 11/25/11,			corrective action will be taken		
		dent #78 enjoyed			facility wide audit was comple		
					to insure that resident care pla	ans	
		and games, exercise,			are in accordance to their		
	walking and wheeling outdoors, shopping, TV, radio, movies. It also				physical, mental, psychosoica	I	
					wellbeing, along with their		
	indicated he di				medical, nursing needs. The D.O.N. or designee will contin		
	groups/organiz	zations, arts/crafts,			to monitor (10) resident's care		
	religious event	s, outings or trips.			plans weekly until 100%		
	_				compliance is met x's (4) wee	ks.	
	The Activities	care plan, dated			Any inaccuracies will be corre		
		ot note the resident's			immediately. Element #3 Wh		
	<u> </u>	ests, just "invite" him to			measures will be put into plac	e or	
		-			what systemic changes you w		
		s to stay in room". The			make to insure that the deficie	-	
	· ·	ventions do not indicate			practice does not recur: At ar	ı all	
	activity prefere	nces.			staff held February 14,2012		
					in-service comprehensive car plans and the purpose and ne		
	During an inter	view with Resident #			to measure objective to maint		
	78 on 1/24/12	at 9:30 A.M., he			the highest practicable physic		
		tended some activities,			mental and psychosocial	<i>'</i>	
		t of his time in his room			wellbeing, along with		
	· •	wasn't much to do.			medical, and nursing needs w	as	
		wash t maon to ao.			reviewed. Element #4 How t	ne	
					corrective actions will be	, [
	2 Posidont #6	91's record was			monitored to ensure the defici		
					practice will not recur; ie what		
	reviewed on 1/	27/12 at 1:20 P.M.			quality assurannce program was been affected by the deficient		
					practice; At the monthly Qual		
		ses included, but were			Assurance meeting monitoring		
	not limited to, i	right hip fracture, hx			results of care plans will be	, l	
	DVT (deep vei	n thrombosis), GERD			reviewed. Any patterns will be	e	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155245	B. WIN			02/01/	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			86TH ST		
CASTLE	TON HEALTH CAR	E CENTER			APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		geal reflux disease),			addressed. If necessary an		
	right lung nodu	ıle, hypothyroidism,			action plan will be written by the Administrator and monitored	ie	
	Parkinson's Disease, depression, and				weekly until resolution.		
	CAD (coronary	artery disease).			weekly until recolution.		
	During review	of Resident #91's					
record, documentation was present							
	indicating the resident had an open area to her right foot,						
	Physician's ord	ders indicated:					
	1	oan ointment to open					
		ry day and as needed					
	, ,	pply 2 x 2 dressing x 7					
	days and re-ev						
	1	oban ointment to right					
		ban onlinent to right					
	foot	-tions due of a continue					
		ntinue treatment to right					
	foot - area reso	olved.					
	The Initial Wou	ınd visit form,dated					
		ted "Pt recently					
		der/red area to R (right)					
	•	urrent tx (treatment)					
	Bacitracin with	,					
		ss note of 1/11/12					
	included: "0.6						
	,	date of etiology					
	1/5/12. Questi 	on of cellulitis."					
	The resident's	Admission					
	Assessment, d	ated 12/15/11,					
	· ·	oot bunion area" (does					
		problem with it) "1+					
	(plus) right foot	,					
	(pida) rigiti 100	Codollia.					

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	OF CORRECTION IDENTIFICATION NUMBER: 155245	A. BUILDING B. WING	00	COMPLETED 02/01/2012
NAME OF PROVIDER OR SUPPLIER CASTLETON HEALTH CARE CENTER		7630 E	ADDRESS, CITY, STATE, ZIP CODE 86TH ST APOLIS, IN 46256	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	The current care plan, dated 1/20/12, addressed edema to the resident's right foot and also indicated she was at risk for skin alteration. During an interview on 1/30/12 10:50 A.M., the DON (Director of Nursing) indicated she was unable to find a care plan addressing the red area to Resident #91's right bunion. During an interview with the ADON (Assistant DON) on 1/30/12 at 11:00 A.M., she indicated "we should have had a care plan addressing the area which was caused by her shoe." 3.1-35(a)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155245		A. BUILDIN		NSTRUCTION 00	(X3) DATE COMPL 02/01 /	ETED	
		133243	B. WING			02/01/	2012
	PROVIDER OR SUPPLIER		76	630 E 8	.DDRESS, CITY, STATE, ZIP CODE 86TH ST APOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	, [(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)	TA		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
			17	10	,		DATE
F0334		evelop policies and					
SS=D	procedures that er						
		the influenza immunization,					
	each resident, or t	eives education regarding					
	-	otential side effects of the					
	immunization;	oternial side effects of the					
		s offered an influenza					
	(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal						
	•						
	•	aindicated or the resident has					
	•	<u>-</u>					
	•	r the resident's legal					
		s the opportunity to refuse					
	immunization; and						
		medical record includes					
		at indicates, at a minimum,					
	the following:						
	(A) That the resid	dent or resident's legal					
	representative was	s provided education					
	regarding the bend	efits and potential side					
	effects of influenza	a immunization; and					
	(B) That the resid	dent either received the					
	influenza immuniz	ation or did not receive the					
	influenza immuniz	ation due to medical					
	contraindications of	or refusal.					
	_	evelop policies and					
	procedures that er						
		the pneumococcal					
		th resident, or the resident's					
		ve receives education					
		efits and potential side					
	effects of the imm	unization; s offered a pneumococcal					
		ess the immunization is					
	•	dicated or the resident has					
	already been imm						
	-	r the resident's legal					
		s the opportunity to refuse					
	immunization; and	· ·					
	minimization, and	1					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPL		
155245			B. WIN	G		02/01/	2012
	PROVIDER OR SUPPLIEF			7630 E	ADDRESS, CITY, STATE, ZIP CODE 86TH ST APOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	documentation that the following: (A) That the residual representative was regarding the beneffects of pneumo (B) That the residual pneumococcal impreceive the pneumococ	oractitioner a second pneumococcal by be given after 5 years pneumococcal ess medically the resident or the presentative refuses the tion.	F03	34	Element #1 What corrective action(s) will be accomplished those residents found to have	for	02/21/2012
	a resident rece vaccine and fairesident's right vaccine was he residents revie vaccines in a S (Resident # 48 Findings included) 1. The record for reviewed on 1/1	acility failed to ensure sived only 1 influenza iled to ensure a to refuse the influenza onored for 2 of 5 wed for influenza stage 2 sample of 37 & Resident # 74).			been affected by the deficient practice; It is the policy of this facility to ensrue that all reside receiving the influenza vaccine that consents are followed in accordance with the resident's resident's legal representative desires. It is also this facility policy to ensre the resident receive only one inluenza vacci annually. Element #2 How will identify other residents having potential to be affected by the same deficient practice and who corrective actions will be taken All residents have the potential be affected by this practice. Resident # 48's legal representative and physician will be taken affected to the same deficient practice.	ents e or cine you the nat	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED		
155245		A. BUII B. WIN			02/01/	/2012		
				_	ADDRESS SITY STATE ZIR SODE			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
0.4071 57011 1541 711 0.405 0511750			7630 E 86TH ST					
CASTLETON HEALTH CARE CENTER			INDIAN	IAPOLIS, IN 46256				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE	
	but were not lir	nited to, Transient			notified about receiving (2)			
	Ischemic Attac	k, Hypertension,			influenza vaccines. Resident			
	Diabetes, Alzh	eimers, Hyperlipidemia,			#74's legal representative and	1		
		ciency, Coronary Artery			physician was notified about	•		
	Disease.	olonoy, coronary ratery			receiving the influenza vaccin even though the signed conse			
	Discase.				stated not to give. Going forw			
	Davidson 60				the signed consent stating to			
		nurses notes on			or not to give the influenza	J •		
		P.M., indicated the			vaccine will be placed into the	!		
	resident had be	een given the influenza			residents chart. A medication			
	vaccine in the	right deltoid by LPN #			sheet will be created for the n	urse		
	1.				giving the vaccine to sign that			
					did review consent sheet prior	to		
	Review of the r	nurses notes on			giving the vaccine. The			
		00 P.M. indicated the			medication sheet will also refle	ect		
					that education was given to			
		een given the influenza			resident, POA, and or legal guardian. The D.O.N. or design	noo		
	vaccine in the l	left deltoid by LPN # 2.			will monitor all new admission			
					ensure policy is followed. The			
	During an inter	view with the Director			D.O.N. or designee will also			
	of Nursing on 2	2/1/12 at 10:00 A.M.,			monitor at immunization time			
		s requested about the			October 1st thru March 31st the	nat		
	resident receiv	•			all consents are followed with			
		indicated at that time,			accordance to resident's or le	gal		
		-			representative wishes and			
		ole building in 3 days			that education given. Elemen			
	and LPN # 2 na	ad been terminated.			What measures will be put int			
					place or what systemic chang			
	At the time of e	exit on 2/1/12 at 12:00			you will make to ensure that to deficient practice does not rec			
	P.M., no furthe	r documentation was			At an all staff in-service give of			
	provided about				February 14, 2012 the policy			
		uenza vaccines.			procedure was reviewed on a			
	300.7.1.19 2 .11111				aspects of reviewing the signe			
	O The managed	for Docidont #74 ···			consent prior to administering			
		for Resident #74 was			Influenza/Pneumonia Vaccine			
	reviewed on 1/	30/12 at 2:00 P.M.			Any nurse who fails to comply	•		
					with guidelines in reviewing			
	Diagnoses for	Resident #74 included			consents prior to administerin			
	_	nited to Dementia			Influenza/Pneumonia Vaccine	will		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, DIHI DI	a. Building 00		COMPLETED				
155245			A. BUILDING B. WING		02/01/2012				
				TD FFT 4	DDDEGG GITW GTATE JID GODE				
NAME OF F	PROVIDER OR SUPPLIE	CR.			ADDRESS, CITY, STATE, ZIP CODE				
CACTIC	TONILIEALTILOAS	DE CENTED		7630 E 86TH ST					
CASILE	TON HEALTH CAP	RECENTER		NDIAN	APOLIS, IN 46256				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE		
	Hypertension,	Insomnia, Depression,			be progressively disciplined up	o to			
	anxiety, Hyper	lipidemia, Dysphagia			and including termination.				
	and Glaucoma				Element #4 At the monthly Quality				
					Assurance Meeting tracking of consents and administration of				
	The resident's	Power of Attorney			the Influenza/Pneumonia Vaco				
		the "Influenza Vaccine			will be reviewed. Any patteren				
	, , , ,				will be addressed. If necessary				
		Consent Form" on			action plan wil be written by th				
		he facility on 8/26/11.			Administrator and monitored				
		cked "No"; the influenza			weekly until resolution.				
	vaccine was n	ot wanted at this time.							
	The Influenza	Pneumonia vaccine log							
	provided by M	edical Records Director							
	on 1/31/12 at	9:20 A.M. and indicated							
	Resident # 74	should not be given the							
	vaccine.	enedia net be given the							
	Vaccine.								
	The "Immuniz	ation Record and TB							
		k Assessment"							
		edical Records Director							
		10:45 A.M., indicated							
	the resident re	eceived the Influenza							
	vaccine on 10	/1/11.							
	The "Medication	on Administration							
	Record" (MAR	R) indicated the resident							
	,	accine on 10/1/11.							
	Interview with	the Medical Records							
		30/12 at 10:30 A.M.,							
	· · · · · · · · · · · · · · · · · · ·	facility made a mistake							
		ne should not have been							
	given to this re	esident.							
	3.1-13(a)								

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	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 155245	(X2) MULTIPLE CO A. BUILDING B. WING	00 	COM	TE SURVEY MPLETED 01/2012
	ROVIDER OR SUPPLIE		STREET A 7630 E	ADDRESS, CITY, STATE, Z 86TH ST APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO ' DEFICIENC	ON SHOULD BE	(X5) COMPLETION DATE

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